ROXBURY PEDIATRICS

KIMBERLY S. KLAUSNER, M.D. **GUY EFRON, M.D.** **CIGAL SHAHAM, M.D.**

INFORMATION REQUIRED FOR CASE HISTORY FILE

TODAY'S DATE ____________________

PATIENT ____________________ SEX __________ BIRTHDATE ____________________

MOTHER/ PARENT 1 ____________________

HOME ADDRESS ____________________

CITY ____________________ STATE ____________ ZIP ____________

HOME PHONE ____________________ CELL PHONE ____________________

FATHER/ PARENT 2 ____________________

- List both addresses if parents living separately -

HOME ADDRESS ____________________

CITY ____________________ STATE ____________ ZIP ____________

HOME PHONE ____________________ CELL PHONE ____________________

MOTHER'S SS# ____________________ MOTHER'S DRIVERS LIC# (include state) ____________________

FATHER'S SS# ____________________ FATHER'S DRIVERS LIC# (include state) ____________________

MOTHER'S OCCUPATION ____________________ BUSINESS PHONE ____________________

EMPLOYERS ADDRESS ____________________

FATHER'S OCCUPATION ____________________ BUSINESS PHONE ____________________

EMPLOYERS ADDRESS ____________________

IS PATIENT COVERED BY INSURANCE? __________ NAME OF COMPANY ____________________

IF GROUP INSURANCE, NAME OF GROUP ____________________

REFERRING PHYSICIAN ____________________

REFERRED BY ____________________

EMERGENCY CONTACT ____________________ PHONE ____________________

I authorize Drs. Klausner, Efron and Shaham and the Staff of Roxbury Pediatrics to render any medical care necessary to my child.

If I am not available and no other legal guardian is available at the time my child is brought to the office, I authorize in advance that care may be rendered in my absence.

____

Signature of parent Date

PATIENT PRIVACY: HIPAA

1) Communications. You can request that our practice communicate with you about the health of your children and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2) You can request a restriction in our use or disclosure of the health information pertaining to your child(ren) with regard to treatment, payment, or health care operations. Additionally you have the right to request that we restrict our disclosure of your child(ren)'s health information to only certain individuals involved in their care or the payment for the care, such as family members. We are not required to agree to your request; however, if we do agree, we are bounc by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to provide treatment.

3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your child(ren), including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Drs. Klausner, Efron, or Shaham, 435 North Roxbury Drive, Suite 311, Beverly Hills, CA. 90210. You may fax the request to 310-657-0986. *There is a standard fee to obtain copies of medical records.*

4) You may ask us to amend your child(ren)'s health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Drs. Klausner, Efron, or Shaham as stated in #3. You must provide us with a reason that supports your request for amendment.

5) Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of the notice, contact any staff member.

6) Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice all complaints must be submitted in writing by faxing or mailing as in #3. You will not be penalized for filing a complaint.

7) Right to provide an authorization for other uses and disclosures, our practice will obtain your written authorization for uses and disclosures that are not identified by the notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies please contact the office at (310) 657-4586

I hereby acknowledge that I have been presented with a copy of Roxbury Pediatrics' Notice of Privacy Practices.

_______________________________ ____________

Signature Date

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Name of Patient(s)

Kimberly S. Klausner, M.D., F.A.A.P.
A Medical Corporation
Guy Efron, M.D., F.A.A.P.
A Medical Corporation
Cigal Shaham, M.D., F.A.A.P.
435 North Roxbury Drive, Suite 311
Beverly Hills, CA 90210
310-657-4586

Dear Parent:

Please initial each item below where there is a blank line to acknowledge that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient.

_____ For patients with no insurance coverage or with insurance where we are not a contracted provider, payment is due at time of service. We accept cash checks, Visa and MasterCard. If we submit claims electronically to your insurance provider as a courtesy, we will NOT accept their discounted rates.

_____ We will bill your insurance carrier for all covered services if you are covered by a plan that we contract with as participating providers. You are required to pay for all co-payments at the time of your visit.

_____ For amounts due after the insurance has processed the claim (such as unmet deductibles, co-insurance, or non-covered services), we will send you three consecutive statements at 30 day intervals.

_____ You have 30 days after the third statement is sent to pay in full the balance indicated on the statement. **If payment is not received in full**, you will receive a notification and your account will be forwarded to a collection agency for further action.

_____ We do not make payment plans for patients with outstanding balances on their accounts. We accept cash, checks, Visa and MasterCard.

It is the responsibility of the patient to notify our office of any change in insurance, mailing address, or contact information.

Your signature below signifies that you have read each item, initialeded each line, and understand your responsibilities to this office.

_________________________________ ____________________
Parent / Guardian's Signature Date

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Child's name